Louisiana Department of Insurance

OFFICE OF HEALTH INSURANCE
Quality Management Division
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HEALTH INSURANCE and HEALTH MAINTENANCE ORGANIZATION
Policy Form Filings

COMMON DISAPPROVAL REASONS

Listed below are the most common reasons found nearly 90% of the time for disapproving health insurance policy forms. Please refer to the GENERAL FILING REQUIREMENTS, COMPLIANCE AND CERTIFICATION STATEMENTS and REGULATORY GUIDANCE FORMS for further direction in assuring the submittal of approvable forms.

Effective March 1, 2001, the Office of Health will disapprove first-time filings and allow no opportunity to correct the forms and resubmit in connection with the original filing. Once disapproved, our record of the filing will be closed. Companies desiring to bring such forms into proper compliance and obtain Departmental approval must submit a new filing along with the appropriate filing fees again.

I. FAILURE TO INCLUDE FILING FEE: No action will be taken on policy form filings received without payment of filing fees. Such filings will be immediately returned in their entirety with a request for payment of the $2.00 per side of a page filing fee.

II. INCOMPLETE FILINGS: See General Filing Requirements for descriptions of what items constitute a complete filing. Such filings will be pended and a letter will be sent identifying the items necessary for the Department to conduct a proper compliance review. Thirty days from the date of our notice that the filing is incomplete will be allowed for our receipt of the company's response. Failure to correctly and timely respond will result in final disapproval of the policy forms submitted and closure of our record of the filing. The company will then have to resubmit a *new* filing with all required items and the appropriate filing fee.

Policy Form Filings determined to be incomplete may NOT be "Deemed Approved" until after expiration of thirty days from the Department's receipt of the requested missing items.

III. IMPROPER GROUPS: See General Filing Requirements for detailed guidance. Such groups include coverage of any type proposed for risks in this state via membership in an association that is not bona fide or; participation in a trust that has not been established by employer or bona fide association or, is not maintained for the benefit of the employees, members, or employees of members. Policy forms filings intended for issue to such improper groups will be disapproved and our record of the filing will be closed.

IV. HIPAA REQUIREMENTS: Warning, individual policies issued to the employees of a Small Employer will be subject to all state and federal HIPAA requirements for guaranteed issue, non-discrimination, and pre-existing condition limitations / portability.

A. Guaranteed Issue / Non-Discrimination – *(Applicable in the Small and Large Group Markets Only)*

1) Actively-at-work and Continuous Service provisions are prohibited. A Small or Large Group plan may not include a rule for eligibility based on whether an individual is *actively-at-work* or is *continuously employed*. A group plan may include a rule for eligibility that requires an individual to begin work for the employer sponsoring the plan before coverage becomes effective.

B. Pre-Existing Condition Limitations / Portability – *(Applicable in the Small and Large Group and Individual Markets except where noted otherwise)* R.S. 22:250.1 – 250.19

1) Pregnancy may not be subject to pre-ex limitations *(This requirement applies only in the Small and Large Group Markets)*
2) Optional maternity coverage offered in the Individual Market must be effective upon election and may only be limited by the pre-ex condition limitation for "A pregnancy existing on the effective date of coverage".
3) Definitions / Limitations regarding sickness, illness, and injury may not conflict with the maximum 12-month limitation on pre-ex conditions and portability in the Individual Market. Examples of improper language would be, "Illness is a medical condition *manifesting* on or after the effective date of coverage" or, "Injuries resulting from an accident occurring on or after the effective date of coverage will be covered".
4) Delayed effective dates of coverage in the Individual Market for treatment of illness or sickness (including specifically named medical conditions such as tonsils, adenoids, etc.) are not permitted due to conflict with portability requirements.
5) Exclusion of coverage for all medical conditions *not disclosed in the application* is not allowed. However, such conditions may be subject to the pre-ex condition limitation and/or challenged under the Time Limit on Certain Defenses or Contestable clauses.
6) The portability period allowed for creditable coverage must be at least 63-days.
7) Small and Large Group health plans may no longer waive part of the pre-ex condition limitation in the event an individual has no claims during the first 6-months following enrollment. A pre-ex condition exclusion is permitted provided it applies uniformly to all *similarly situated individuals* and is not directed at individual participants or beneficiaries based on any health factor of the participants or beneficiaries.

C. Guaranteed Renewability – *(Applicable in the Small and Large Group and Individual Markets except where noted otherwise)*

1) An insurer's unilateral right to amend or modify coverage at renewal must provide for a 90-day notice, see Directive 147
2) Minimum participation requirement may not exceed 75% *(This requirement does not apply in the Individual Market)*
3) Only HMO contracts may contain a provision for non-renewal of coverage when no enrollee or individual resides or works in the service area designated for a provider network.

V. POLICY PROVISIONS:

A. Mandated Benefits

1) Missing mandated benefits
2) Mandated benefits must be properly disclosed in the Benefits Section of the policy. Coverage of a mandated benefit may not be merely assumed as covered or, only noted in the Exclusions / Limitations section of a policy as inapplicable to a particular exclusion or limitation.
3) Missing mandated benefit options. Policy forms for a plan that includes all mandated benefit options may be filed or, the policy forms filed must include optional riders or other mechanism for adding the elected coverage and the options must be contained on the application for coverage allowing for selection by the applicant.
4) Deductibles should be clearly waived for the mandated benefits required for pap test, mammography and prostate cancer screening.
5) Only HMOs may limit or reduce coverage for mandated benefits received "out of network". Indemnity plans must cover mandated benefits regardless whether or not a PPO provider is utilized.

B. Exclusions / Limitations / Improper Definitions

1) Inconsistent exclusions. Any exclusion that may apply to a mandated benefit should reference the mandated benefit and acknowledge that the exclusion does not apply.
2) Discriminatory limitations directly affecting Chiropractors or, that primarily affect a chiropractor's scope of practice, ex. Limiting the number of outpatient visits for "physical therapy" or other forms of treatment for disorders of the back or spine.
3) Ambulance coverage may not be limited to ground transport and must include provision for air or surface transport of a newly born dependent and the child's temporarily disabled mother. (These requirements do not apply to limited benefit, supplement health insurance policies)

4) Definition of *Emergency Medical Conditions* or similar terminology for treatment rendered in an emergency setting cannot be held to "medical necessity" requirements and exclude coverage if the condition is later determined not to have required emergency treatment. Such policy provisions must recognize and cover conditions that would lead a prudent layperson, acting reasonably and possessing an average knowledge of health and medicine, to believe that the absence of immediate medical treatment could reasonably be expected to result in placing their health (or that of their unborn child) in serious jeopardy, serious impairment to bodily function, or serious dysfunction of any bodily organ or part.
5) The complete definition of disability must include "…disability from engaging in an occupation that provides him with substantially the same earning capacity as his former earning capacity".
6) Exclusion of coverage for treatment of injuries resulting from "any drug" is too restrictive.
7) Benefits may not be denied for treatment rendered in a medical facility owned or operated by the state of Louisiana or any of its political subdivisions, i.e. "Charity Hospitals".
8) "Source-of-injury" exclusions based on any health factor are discriminatory. As Small and Large Group health plans generally provide coverage for injuries, such plans may not deny benefits for treatment of an injury resulting from a medical condition, including both physical and mental health conditions. For example, plan exclusions for self-inflicted injuries or injuries sustained in connection with attempted suicide are discriminatory because depression is a medical condition. (These requirements do not apply to policies issued in the Individual Market or to limited benefit, supplement health insurance policies.)

C. Dependent Coverage

1) Improper limiting ages for dependents.
2) Failure to include grandchildren in definition or provision for dependent coverage.
3) Newborn children must be covered automatically from birth for one month or *until well enough to be discharged from the hospital or neonatal special care unit*, whichever period is longer.
4) Failure to provide for continued coverage of a dependent who is an unmarried student under the age of 24 and who has developed a mental or nervous condition causing the student to be unable to attend school as a full-time student.
5) Definition of a dependent child may not be tied to any financial dependency requirement except for continuation of coverage beyond the limiting age for handicapped children or for an unmarried student under the age of 24 and who has developed a mental or nervous condition causing the student to be unable to attend school as a full-time student.
6) Failure to provide for continuation of coverage for a surviving spouse of the insured.

D. General Provisions

1) Subrogation may not begin until the claimant is fully compensated.
2) Arbitration provisions must allow for election by claimant and may not be binding.

3) Notice period for change in premium must be at least 45-days for any increase of 20% or more in the premium rate.
4) Insufficient grace period or failure to include a grace period provision.
5) "Coordination of Benefit" and other provisions having similar effect found in *individual policies* may be less favorable than the optional "Insurance With Other Insurers" provision allowed by law. Any such provision that reduces coverage by the amount of benefits paid or payable by "Other Insurance" must include an exception for the benefits paid under limited benefit plans. Essentially, no reduction of benefits payable under major medical types of coverage may be based upon the amount of benefits paid under a limited benefit, supplemental health insurance policy. Additionally, such provision for reducing benefits must include language addressing the potential situation where the "Other Insurance" policy contains the same or similar provision for reducing coverage and, language allowing for eligible expenses to be covered at least up to 100% by the combined coverage.
6) Notice of cancellation / non-renewal of coverage under limited benefit plans only, must be 60-days.
7) Failure to include the required provision for "Extension of Time Limitations".
8) "Payment of Claims" provisions must indicate that benefits will be paid *immediately upon receipt of written proof of loss*. However, should the health insurance policy or group plan include specific time periods for payment of claims, the following time periods apply to all types of health insurance except for limited benefit, supplemental insurance and short-term major medical policies:

    - Non-electronic claims submitted by contracted providers shall be paid not more than 45-days from the date a correctly completed uniform claim form is furnished to insurer. If submitted more than 45-days from the date of service or resubmitted because the original claim was incomplete, benefits shall be paid not more than 60-days from the date a correctly completed claim form is furnished;

    - Non-electronic claims submitted by non-contracted providers shall be paid not more than 30-days from the date a correctly completed claim form is furnished;

    - Claims submitted electronically shall be paid not more than 25-days from the date a correctly completed uniform claim form is electronically transmitted to the insurer; or

    - The health insurer may elect a 30-day payment standard by providing written notice to the Commissioner.

9) Limited benefit, supplemental insurance and short-term major medical policies shall provide for payment of claims not more than 30-days from the date upon which written notice and proof of claim are furnished to the insurer. However, accidental death policies shall provide for settlement of claims within 60-days of receipt of due proof of death.

E. Inconsistent, Ambiguous, Or Misleading Clauses

1) Policies entitled as basic hospital expense, basic medical / surgical expense or other major medical insurance and marketed as providing better benefits for medical services received within a provider network, must also provide for a reasonable level of indemnification for services received outside the provider network. No policy forms will be approved which allow for coverage at a coinsurance level of less than 50% of billed or reasonable and customary charges.
2) Varying coinsurance levels and any penalties for failure to pre-certify must be clearly and prominently disclosed.
3) The terms of any group policy covering risks in this state may not contain a provision that the policy is construed according to the laws of another state.

F. Application

1) Failure to include a Genetic Disclosure statement.
2) Health questions must be restricted in scope to those persons applying for coverage.
3) All options for deductibles, coinsurance levels, benefits available to the applicant must be printed on the application.
4) If the policy provides for payment of benefits to a beneficiary, the application must include a place for the insured to designate the beneficiary.
5) All applications and enrollment forms must contain required Fraud Warning language.